ARC 0583C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 7, "Appeals and Hearings," and Chapter 88, "Managed Health Care Providers," Iowa Administrative Code.

These amendments add language to ensure that managed care organization (MCO) network providers who seek a state fair hearing on behalf of a Medicaid member have involved the member and have that member's specific consent to pursue a state fair hearing.

These amendments conform the rules of the Department to federal regulations that require consent of the member when a network provider requests a hearing. 42 CFR 438.402 specifically requires written consent of the member.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0435C** on October 31, 2012.

As the result of internal review of the proposed amendments, the following changes were made to the amendments published under Notice of Intended Action:

New Items 1 and 2 were added to amend Chapter 7, "Appeals and Hearings," for clarity and consistency in the processing of appeals where state fair hearings have been requested by providers. As a consequence, proposed Items 1 and 2 were renumbered as Items 3 and 4.

New subrules 88.8(6) and 88.68(7) in Items 3 and 4 have been revised to ensure that a state fair hearing will only be granted when a network provider submits a document providing member approval of the request with the request for state fair hearing. Specifically, the final sentence in subrule 88.8(6) and subrule 88.68(7) has been omitted to eliminate the instruction for administrative law judges to dismiss any request for a state fair hearing that does not comply with all the requirements of the subrule. If the member's approval is not submitted with the request for fair hearing, the fair hearing request will be denied by the Appeals Section of the Department.

The Council on Human Services adopted these amendments on January 9, 2013.

These amendments do not provide for waivers in specified situations because all Medicaid providers who are members of a managed care organization (MCO) should be subject to the same requirements. However, requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

The following amendments are adopted.

ITEM 1. Amend rule **441—7.1(17A)**, definition of "Aggrieved person," as follows:

"Aggrieved person" means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. to 6. No change.

7. For providers, a person or entity:

- Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.
- Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.
- Whose contract as a Medicaid patient manager has been terminated.
- Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).
- Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.

- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.
- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).
- Who, as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member, has a dispute regarding payment of claims.

8. to 12. No change.

ITEM 2. Amend paragraph **7.5(2)"a"** as follows:

a. One of the following issues is appealed:

(1) to (17) No change.

(18) An MCO provider or Iowa plan contractor fails to submit a document providing the member's approval of the request for appeal.

ITEM 3. Adopt the following **new** subrule 88.8(6):

88.8(6) *Consent for state fair hearing.* Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

ITEM 4. Adopt the following **new** subrule 88.68(7):

88.68(7) *Consent for state fair hearing.* Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[Filed 1/9/13, effective 4/1/13]
[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.